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EXECUTIVE SUMMARY **

MADAM CHAIR, MEMBERS OF THE ROYAL COMMISSION , LADIES AND GENTLEMEN,

The Alberta Advisory Council on Women's Issues (AACWI) is a citizens' advisory council composed of 15 women appointed by the Government of Alberta. As a Council, we represent Alberta women of all ages, religions, cultures and lifestyles. The Council is, therefore, addressing the issue of new reproductive technologies (NRTs) as they relate to women's reproductive health and well-being from a very diverse perspective. It is not a scientific, a legal or a medical perspective. While all of these areas are crucial to any discussion of new reproductive technologies, the **Council believes that the most important perspective of all is the one brought by women themselves.**

**Presentation made before the Royal Commission by Elva Mertick, Chairperson of the Alberta Advisory Council on Women's Issues September 13, 1990.

In presenting this brief, I will elaborate on some of the implications of NRTs for women's health and well-being within the context of three categories already identified by the Royal Commission.

1) problems and treatments associated with infertility; 2) procedures and techniques which focus on the embryo or fetus; and

3) use of fetal tissue and "genetic material" in research on and treatment of disease.

Above all, the Council is concerned with choice for, and control by women, in all areas of reproductive health. **The ability to exercise control is central to the issue of reproductive choice for women and the Council is staunchly in favor of women assuming responsibility for their own reproductive choices. At the same time, until more women actually believe they have control and choice, they will not take control, or seek out the choices.**

Problems and Treatments Associated with Infertility

Our society's response to problems of infertility for which the Council suggests the replacement term, subfertility, has become restricted. Subfertility is viewed as simply an aberration of nature which can be corrected by human technological intervention. Our society continues to commit substantial resources to subfertility treatment programs and, at the same time, **it appears to be unwilling to give equal consideration to preventive measures. We need better access to the available information and greater understanding about reproductive health in general.**

Any discussion of choice for women must also include questions about who is exercising control over these choices and about the criteria being used to make them. Furthermore, **the choice of whether or not to pursue a particular course of treatment is limited by factors such as accessibility of information and services, economic resources and socio-cultural values.**

Intervention invariably focusses on women's bodies regardless of the cause of subfertility. While a relatively small professional community is developing and marketing an enormous field of technology, **it is women who are assuming the very real risks and costs to their health and well-being.**

B. Artificial Insemination

In terms of the hierarchy of technology, artificial insemination is perhaps the least sophisticated and least invasive of women's bodies. Indeed, women have been able to make use of the benefits of artificial insemination, without professional intervention, thus allowing them to retain control over important decisions. **Artificial insemination, when offered by the medical profession, may be attached to cultural and economic values which effectively limit women's access to the services provided.**

Important decisions are generally made by the professional community. Standards of screening for donors, fee scales and the degree of anonymity are examples of decisions **in which women seeking to use medically assisted artificial insemination have little input**.

In many cases where artificial insemination is used, subfertility is the result of a male partner's sterility. There appears to be a lack of interest or inquiry by the medical and scientific community in investigating and treating male-related causes of subfertility.

C. In Vitro Fertilization (IVF)

Although the tangible costs, such as the economic expenses, and the risks, such as the high failure rate, can be spelled out to a woman offered the choice of pursuing In Vitro fertilization, it is not always clear that she is able to make a real choice because of several factors. **One of these is the very real limit placed on her ability to control a process which necessarily affects her in the most fundamental and intimate way.**

A woman who chooses to undergo IVF must rely on a community of experts. **Her decision to interact with these professionals requires that she make profound changes to her view of herself, her body and her world. She must trust what others tell her about what is happening to her body, and she cannot rely on her own knowledge.**

In addition to possible physical discomfort, and the potential risks associated with drug therapy, IVF profoundly alters a woman's experience of pregnancy and her relationship with her body. **With IVF, the process of becoming pregnant is fragmented in a way that deeply affects a woman psychologically.** Once involved in the IVF process, however, women can become very vulnerable to feelings of personal inadequacy and failure.

Just as women in earlier stages of subfertility are told that pregnancy often occurs when they stop thinking about it so much, women engaged in IVF are told that in some mysterious and not yet understood way their bodies and their mental attitude are contributing to the success or **failure** of the treatment.

If a woman whose stated goal is to become pregnant and give birth to a child becomes pregnant, but suffers a loss of health and well-being or gives birth to more than one child, how is the success of the intervention to be measured? **And how is the woman to evaluate whether or not she has made a real choice?**

D. Surrogacy

Men who donate their sperm, when they are paid at all, receive remuneration for their time and inconvenience, not for the actual sperm. However, when women are asked to donate their eggs in addition to providing an "environment" in which a fertilized egg can mature, **the factors of time and inconvenience cannot be viewed similarly**. The woman in question will be precluded from engaging in certain activities, such as employment, at least for a portion of time, and she will be required to provide not only her time but also her labour before a child can be born.

A woman entering into a surrogacy contract cannot avoid mingling the rights and interests of the "product" (the child) with the "owner/producer" (herself). **The potential for the development of an adversarial relationship is immediately raised.**

The separation of the stages, functions and processes of pregnancy through IVF is mirrored in the fragmentation of **parenting** through surrogacy. Although the technology exists to achieve this reality, the social, legal and psychological abilities to grapple with it do not.

This kind of fragmentation of the processes of pregnancy and parenting will demand that our society clearly articulate and expand the meanings of concepts such as "mother," "father" and "family." **To date, it is blatantly clear that our society is unable to do so.**

Procedures and Techniques which Focus on the Embryo or Fetus

Advances in medicine, particularly in the area of fetal surgery, also contribute to the further fragmentation of pregnancy. This separation of mother and fetus or embryo has profound implications for women and their ability to make choices about treatment they will receive from professionals, such as physicians and lawyers. Women are at risk of losing control over decisions regarding the birthing process, treatment they receive throughout a

pregnancy, interventions aimed at terminating a pregnancy, and even procedures that take place before conception.

If the embryo/fetus is granted legal or social status as a separate being, the possibility exists that someone other than the woman, of whose body it is a part, will be given the authority to make choices about the welfare of that embryo/fetus. In Canada and the United States, there have been alarming indications in recent court decisions and in legislation that women are being seen primarily as **environments** for the production and raising of children. **This represents a failure to recognize women as autonomous individuals, with a right to exercise control over their own bodies.**

D. Sex Pre-Selection

Women are especially concerned about the well documented and pervasive preference of people all over the world to have male children, especially as first borns.

We need to recognize that the problem lies with the societies which encourage this preference not with the technology per se. Society benefits from having women and men who have mixed places in the birth order. The two genders use the various birth order characteristics and abilities in different and important ways.

Use of Fetal Tissue and "Genetic Material" in Research on and Treatment of Disease.

The issues surrounding the use of fetal tissue and "genetic material" are connected to the issue of **control**. They are also predicated on socio-cultural ideas about the concept of **ownership.** As the new reproductive technologies help to strengthen the view that reproductive processes can be fragmented and broken down into discrete parts, it is inevitable that our society will be left to grapple with decisions about who owns those parts.

Strong arguments can be made in favour of granting ownership of fetal tissue or "genetic material" to the women from whose bodies it has come. The precedent for this assertion stems from the general presumption of the need for informed consent from any person who gives up any part of her or his own body. **The Council believes it is not morally right to take blood, skin or organs from a person without their informed consent, no matter how urgent the need.**

There is no doubt that benefits are available from using fetal tissue or "genetic material." Questions as to who benefits from donations of tissue or material must be asked. However, the central focus must be on the aspect of donation -- who has the right to give -- and not on the question of who benefits, or who has the right to take. **The Alberta Advisory Council on Women's Issues strongly believes that women must make these decisions for themselves.**

CONCLUSION

Women must be active participants in all the decision-making processes associated with the new reproductive technologies because of the intimate connection between these technologies and women's bodies.

Women must be viewed as whole persons, rather than as a collection of reproductive parts. Fragmentation of the process is a fragmentation of women.

There is an equally pressing need for our society to evaluate and priorize goals and procedures from within a wide social context in which the values of the scientific community would form only one part of the general analysis and policy setting. **In particular, the voices of women must be heard and heeded.**

This does not mean that scientific knowledge is not valuable, but it does indicate that society cannot assume that this knowledge is infallible. It is necessary to consider that while women may make choices that are based on their own needs and values, so too do those people who intervene, ostensibly as objective and neutral parties.

A woman who is not informed fully will be restricted by the range of choices open to her and a woman who is restricted from exercising choice will not be helped by the provision of information. These two elements cannot be separ ted.

The Alberta Advisory Council on Women's Issues is aware that new reproductive technologies can benefit women and our society as a whole. We do not disagree with the development of these technologies, our concerns lie in their application. The Council supports the need for continued research and urges the Royal Commission to make recommendations which give women absolute and final choice and control over their own reproductive destinies.

INTRODUCTION

The Alberta Advisory Council on Women's Issues (AACWI) is a citizens' advisory council composed of 15 women appointed by the Government of Alberta. As a Council, we represent Alberta women of all ages, religions, cultures and lifestyles. The Council is, therefore, addressing the issue of new reproductive technologies (NRT) as they relate to women's reproductive health and well-being from a very diverse perspective. **It is not a scientific, a legal or a medical perspective.** While all of these areas are crucial to any discussion of new reproductive technologies, **the Council believes that the most important of all is the perspective brought by women themselves.**

The Alberta Advisory Council on Women's Issues strongly supports the Royal Commission's view that the implications of NRTs for women's reproductive health and well-being are "one of the most important aspects of its mandate".

In presenting its brief to you, the Council will elaborate on some of the implications of NRTs for women's health and well-being within the context of three categories already identified by the Royal Commission.

1) problems and treatments associated with infertility

2) procedures and techniques which focus on the embryo or fetus and

3) use of fetal tissue and "genetic material" in research on and treatment of disease, or for other purposes.

The Council's central concerns relate to choice for women, and to control by women, particularly because choice and control are so inextricably interwoven. The ability to exercise control is central to the issue of reproductive choice for women and the Council is staunchly in favor of women assuming responsibility for their own reproductive choices. **At the same time, until more women actually believe they have control and choice, they will not take control or seek out the choices.**

1. Problems and Treatments Associated with Infertility

A. General

The development of many treatments for infertility is generally seen as having increased women's abilities to make choices about the reproductive aspects of their lives. Women who at one time may have been unable to conceive a child may now be able to avail themselves of medical services, such as artifical insemination or in vitro fertilization, or of medical-social services, such as surrogacy. However, **any discussion of choice for women must also include questions about who is exercising control over these choices and about the criteria being used to make them.**

Furthermore, the choice of whether or not to pursue a particular course of treatment is limited by factors such as accessibility of information and services, economic resources and socio-cultural values. This raises a complex set of questions: How informed are women who seek to use these new and complex technologies? How many women are able to afford the emotional, physical and financial costs of such treatment? Are women who are poor, single or lesbian offered the same choices as women who are wealthier, married or heterosexual?

It is necessary to ask if the desire to produce a biologically related child is always best met by efforts to provide such a child. Most of the new reproductive technologies are developed with the aim of producing a desired child for each couple. In so doing, **these technologies may be increasing the pressure many people feel to have a child of their "own" while discouraging consideration of alternate ways in which people could nurture children to whom they are not biologically related.** In general, options such as adoption, foster parenting or other less traditional relationships with children are not presented or discussed fully by advocates of the new reproductive technologies.

The inability of many couples to produce their own biological child is generally assumed to be the underlying rationale for the creation of services and techniques which may provide a solution for their dilemma. However, there are a number of assumptions in this view which have received little attention and, as a result, there are many questions which are rarely raised. For example, the definition of infertility itself is not well articulated and the Council suggests the replacement term, subfertility. In Canada, a couple who has been unable to conceive a child after one year is considered to be infertile. While sterility is defined as the inability of one person to contribute to the

creation of a new human being, infertility is the inability of a couple to produce a biological child and subfertility can be seen as the inability of a couple to produce a biological child within a given period of time. **Subfertility, therefore, is not necessarily attributable to inability per se, or to any particular individual.**

As a society, we are living in a time of new myths. In general, we have come to believe that it is easy to become pregnant -- or not to become pregnant. However, despite the advances of scientific knowledge and technology, this is clearly not the case. The complex and powerful workings of human beings, on physiological, emotional and social levels, continue to exert their influence in spite of the most sophisticated technologies. Subfertility is only one such manifestation. It is not a disease, nor can it be treated as such. Treatment for subfertility seeks to circumvent a set of conditions, not to alter them in a permanent way. Too often, the language of technology hides the fact that the "cures" for subfertility are social as well as medical. A technological perspective encourages us to believe that the components of medical intervention come from an abstract, scientific manipulation of reproductive materials in some remote laboratory. **In reality the basic materials, eggs and sperm, necessary for technological intervention are produced by human beings.**

Our society's response to problems of subfertility has become very restricted in the sense that subfertility is assumed to be simply an aberration of nature which can be corrected by human technological intervention. Our society is reluctant to consider that it has any role in contributing to this "aberration" and that we might therefore be able to prevent some of the problems of subfertility. The conditions which contribute to subfertility include a wide range of causes, only some of which are known. Of the ones that are identifiable, many receive little attention or treatment. For example, a substantial number of persons who are being treated for subfertility are experiencing difficulties because of the results of sexually transmitted diseases, sterilization or environmental factors. **While our society continues to commit substantial resources to subfertility treatment programs, it appears to be unwilling to give equal consideration to preventive measures.** Again, modern technology leads many to believe that any damage done can be undone simply. **Prevention of the damage in the first place is largely ignored. There is a need for better access to the available information and for greater understanding about reproductive health in general.**

Intervention invariably focusses on women's bodies regardless of the cause of subfertility. While a relatively small professional community is developing and marketing an enormous field of technology, **it is women who are assuming the very real risks and costs to their health and well-being.**

B. Artificial Insemination

In terms of the hierarchy of technology, artificial insemination is perhaps the least sophisticated and least invasive of women's bodies. Indeed, women have been able to make use of the benefits of artificial insemination, without professional intervention, thus allowing them to retain control over important decisions. For example, women who choose to use artificial insemination without the assistance of medical or legal professionals work out for themselves many of the details involved in obtaining sperm. They are able to decide whether or not to use the sperm of men known to them, and to obtain and provide as much or as little information as they wish about themselves and the donor.

Women's ability to exercise control is central to the issue of reproductive choice for women. Even artificial insemination, which arguably offers women the greatest degree of control and choice, presents difficulties. **Artificial insemination, when offered by the medical profession, may be attached to cultural and economic values which effectively limit women's access to the services provided.** For example, many clinics have made their services available only to married or heterosexual women involved in a long-term relationship. Single women or lesbian women may therefore not be able to avail themselves of these services.

Other important decisions are also generally made by the professional community. **Standards of screening for donors, fee scales and the degree of anonymity are examples of decisions in which women seeking to use medically assisted artificial insemination have little input.** Yet, the health and well-being of women are significantly affected by these decisions. A woman may or may not wish to have extensive information about a sperm donor; however, she is not the one who decides what information is pertinent to decisions on the suitability of donors.

In many cases where artificial insemination is used, subfertility is the result of the partner's sterility. There appears to be a lack of interest or inquiry by the medical

and scientific community in investigating and treating male-related causes of subfertility. **Inevitably, it is women who become the designated patients and who undergo the prescribed treatments.**

Other important considerations for women using artifical insemination stem from the potential for conflict between society's beliefs such as those regarding paternity and the dilemmas posed by scientific advances. **The status of a woman who has been inseminated by donor, as well as that of her child, is unclear.** In some minds, a married woman who has been inseminated by donor is an adultress. Similarly, a child conceived by donor insemination may be considered to be illegitimate. Particularly worrying are questions of "ownership" of a child who results from donor insemination. Questions of paternity have traditionally been settled on the basis of genetic connection, and not on that of fatherhood as a social role. However, even where it is framed through an understanding of social roles, paternity is usually seen as being a result of the relationship between a man and the biological mother of the child, and not from the relationship between that man and the child. This issue certainly has ramifications for men. How does the donation of sperm affect the question of paternity and more particularly the rights and responsibilities of fatherhood?

The very framing of this question has even more far-reaching implications for women. If a woman is inseminated by donor, what exactly is the nature of that donor's "gift?" Can a man who donates his sperm later assert his rights as a father? At what point is a woman who has been inseminated a mother? When egg and sperm join together to form an embryo, who can decide who owns that embryo? Can a pregnant woman ever be justifiably viewed as simply a vessel or the environment in which a man's "seed" grows? **The answers to these questions have important implications for all women because they have a profound effect on our society's view of women, their bodies, and their autonomy as members of our society.**

C. In Vitro Fertilization (IVF)

In vitro fertilization (IVF) has received a great deal of attention from the professional community and the general public alike. Perspectives on this highly sophisticated technology can be viewed as a continuum, one end of which enthusiastically views IVF as a wonder of human achievement while the other end casts dubious eyes toward the unknown and uncertain elements that always accompany new knowledge.

The Alberta Advisory Council on Women's Issues believes the promises of benefit contained in IVF cannot be separated from the potential risks and concerns. What is required is a careful analysis which assesses both benefits and costs from the most diverse and comprehensive perspectives.

IVF is a new and highly experimental technique. The rapidly growing number of clinics and patients does not alter the fact that there is still more unknown than known about IVF. The relatively few births that have resulted from IVF provide us with little data, all of which are short-term; but the effects of IVF work are long-term. They will be with us not only as the current generation of children and women mature but also as their future generations are born and live out their lives. However, there are some observations that we can make even at this early stage.

IVF promises the opportunity for a woman to raise a child carried within her own body. It is an opportunity that comes with a substantial price tag for women in terms of financial, physical and emotional costs. Although the tangible costs, such as the economic expenses, and the risks, such as the high failure rate, can be spelled out to a woman offered the choice of pursuing IVF, it is not clear that she is always able to make a real choice because of several factors. One of these is the very real limit placed on

her ability to control a process which necessarily affects her in the most fundamental and intimate way.

A woman who chooses to undergo IVF must rely on a community of experts who have licensed access to the resources required by a complex and sophisticated technology. **The decision to interact with these professionals requires that a woman make profound changes to her view of herself, her body and her world. She must trust what others tell her about what is happening to her body, and she cannot rely on her own knowledge.** She cannot determine which drugs, or in what quantities, will help to achieve the pregnancy she desires, or even if they will be beneficial or harmful to her. She may know that the side effects of some drugs include extreme mood swings, headaches, nausea and many other unpleasant sensations, but in choosing to pursue IVF she must find a way to put aside her discomfort, pain or anxiety in the belief that it will be a worthwhile risk. She may know that other consequences include the increased risk of extra-uterine pregnancies, multiple births, miscarriages, premature births, birth defects, perinatal mortality or a complicated delivery, all of which are also risks of normal pregnancies; but she must also find a way to accept these risks in order to attempt the birth of a child. Her future health and that of any child she conceives may also be adversely affected.

It has been observed that IVF differs from natural pregnancy in several critical ways (*Williams, 1988: 153).* In addition to the physical discomfort and pain experienced by the woman and the potential risks associated with drug therapy, **IVF profoundly alters a woman's experience of pregnancy and her relationship with her body. With IVF, the process of becoming pregnant is fragmented in a way that deeply affects a woman psychologically** and that contributes to her willingness to "keep trying."

IVF makes it possible to know exactly at what stage of a pregnancy failure has occurred. This knowledge can create a powerful belief that the problem, once identified, can be corrected and that future attempts with IVF will bring the woman one step closer to a successful pregnancy. In this way, each attempt with IVF is linked with following attempts and a sense of having made progress evolves. In fact, there is little evidence that such a link exists, and identification of a problem at one stage offers no guarantee that elimination of that problem will mean a successful outcome. It may be possible to ascertain what has gone wrong and continue to be largely ignorant of why. Indeed, there is often no way of knowing why a woman's body refuses to carry a baby to term; yet there is a persistent belief that eventually we human beings will be able to fix

anything and everything that goes wrong with "Mother Nature."

It is indeed a peculiarity of IVF that while women are able to put their trust and hope in a technological procedure rife with uncertainty, they are additionally willing to take responsibility for a great deal of that uncertainty. Although women are generally informed of the limitations of IVF, they are also aware that much of that uncertainty is a result of a lack of understanding about how their bodies work. **Just as women in earlier stages of subfertility are told that pregnancy often occurs when they stop thinking about it so much, women engaged in IVF are told that in some mysterious and not yet understood way their bodies and their mental attitude are contributing to the success or failure of the treatment** *(Williams in Overall, 1989, 134).* As one writer has observed: "Calling a 'chemical pregnancy' (a positive pregnancy test even if the woman 'miscarries' in time for a normal period) a success is a way of shifting blame for the failure to achieve a baby from the clinic staff (**we** got you pregnant) to the woman (**you** lost it)" *(Rothman, 1989, 148).*

Within the technology of IVF, there is the familiar belief that if only women's bodies could be understood and mastered, desired results would be achieved. But who defines "desired results?" For example, it may be desirable

from the point of view of an IVF team to stimulate "super ovulation," to fertilize more than one egg and to implant several embryos because this would appear to improve the chances of a successful implantation and pregnancy. However, if the results of super ovulation include discomfort or damage to a woman's health, present or future, and the result of implanting more than one embryo is multiple births, with attendant complications, can this be said to have achieved the "desired result?" If a woman whose stated goal is to become pregnant and give birth to a child becomes pregnant, but suffers a loss of health and well-being or gives birth to more than one child, how is the success of the intervention to be measured? And **how is the woman to evaluate whether or not she has made a real choice?**

Like artificial insemination, IVF is sometimes used when the source of subfertility lies with the woman's partner. Where the quality of a man's sperm is too poor even to attempt artificial insemination, and where the couple is committed to achieving impregnation through the use of his sperm (as opposed to using the sperm of a donor male), IVF remains an option. Once again, questions must be raised as to why so little research has focussed on treating male subfertility. **IVF involves no direct risks to the health and well-being of men. Use of IVF in such circumstances always means that women are assuming**

responsibility and risks in order to overcome a problem that may not stem from their own inability to conceive.

Once involved in the IVF process, however, **women can become very vulnerable to feelings of personal inadequacy and failure.** Studies have indicated that it is very difficult for women in an IVF program to decide to "stop trying" *(Williams, 1988, 153).* This experience has also been reported by women in Alberta who have tried IVF before turning to adoption *(Personal communications to the Alberta Advisory Council on Women's Issues researcher).*

D. Surrogacy

Although the concept of surrogacy has existed in one form or another for a very long time, the new reproductive technologies have introduced new questions and dilemmas. Not only is it possible that a man's sperm can be used to inseminate the egg of a woman other than his wife or partner, it is also possible that a couple could choose a surrogate in whose uterus their already conceived embryo could be placed. These two scenarios present different questions, but they also share common ground.

Comparisons have been made between surrogacy and artificial insemination: If a woman whose husband cannot provide viable, healthy sperm can receive the donation of another man's sperm, then why should a man, whose wife is unable to conceive or sustain a pregnancy, not be able to receive the donation of another woman's egg? The most obvious difference, of course, is that not only does the man require the woman's egg, but he also requires the use of her entire physical body. **Furthermore, the woman will always be in a position whereby the developing embryo/fetus and she are engaged in some kind of relationship, in a way that a man who donates his sperm is not.** This basic, biological fact also accounts for differences in payment for these "donations." Men who donate their sperm, when they are paid at all, receive remuneration for their time and inconvenience, not for the actual sperm. It will be obvious to everyone that, using this basis to calculate a fee, sperm donors do not receive large sums of money since the amount of time or inconvenience is relatively minimal. However, **when women are asked to donate their eggs in addition to providing an "environment" in which a fertilized egg can mature, the factors of time and inconvenience cannot be viewed similarly.** The woman in question will be precluded from engaging in certain activities, such as employment, at least for a portion of time, and she will also be required to provide not only her time but also her labour before a child can be born.

As a society, we may question how to calculate a fair payment for the services of a surrogate mother; or whether there is a fundamental flaw in thinking that any value can be assigned to such services. Certainly, there is greatly divided opinion on this matter. On the one hand, advocates argue that a woman should be able to choose to offer these services and should be paid for them. On the other hand, opponents argue that no one's body can be used in this way. Comparisons are made between the sexual services of a prostitute and the reproductive services of a surrogate. Both are selling parts of their bodies *(Corea in Corea et al., 1987, 39)*. However, the outcome of sexual services presumably consists of sexual gratification, while the successful outcome of reproductive services results in a living human being, opening the way for competing ownership claims. To date, resolution of such claims through moral and legal debate has been unsatisfactory, leading many to conclude that surrogacy contracts should not be recognized. It is not clear what, if anything, would constitute appropriate terms for such a contract, in large part because our society is unable to specify exactly the nature of the service being provided. A woman entering into a surrogacy contract cannot avoid mingling the rights and interests of the "product" (the child) or its "owner" with the "producer" (herself). The

potential for the development of an adversarial relationship is immediately raised.

Framing the questions in this way also raises thorny issues for women. Where a man contracts with a woman for her to provide her reproductive capabilities, ensuing conflicts over any child produced tend to be framed as between the two of them. This has led some people to suggest that the term "surrogate mother" ought to be replaced by "surrogate wife." Although this rephrasing does capture some of the reality of the situation, it serves to emphasize the relationship between the man and surrogate, while minimizing the equally real relationship between the surrogate woman and the child whom she has nurtured for nine months. In any case, the man's wife, because she is not seen as having any part of the original contract and because she has no claim to any rights as a mother, is left in the peculiar position of outsider. Furthermore, as the man's partner, she may feel obliged to support him in his claim to the embryo/fetus while also sensing that there is something wrong with opposing another woman in her claim to keep and raise a child whom she has borne and nurtured.

A father in a surrogacy arrangement is not donating or selling his sperm. He is buying something, but what *(Rothman, 1989, 232)*? He may be said to be buying services or capabilities; or he may be said to be renting space. All of these constructions ignore the relationship between the biological mother and her embryo/fetus, and insist that women can sell or rent parts of themselves *(Rothman, 1989, 244)*. An alternative construction views the father as buying a baby, but this creates difficulties as well. Many people are vehemently opposed to such a notion being legally or morally sanctioned. Others believe that a man cannot buy what is already his; but what makes a baby "his" *(Rothman, 1989, 232)*?

The separation of the stages, functions and processes of pregnancy through IVF is mirrored in the fragmentation of parenting through surrogacy. Although the technology exists to achieve this reality, the social, legal and psychological abilities to grapple with it do not. The idea of open adoption, for example, with its rejection of secrecy, and its formulation of the concept of two sets of parents has only recently been accepted. It is important also to recognize the work that is required of many adoptive couples in order to shake off stigmas associated with subfertility and adoption, and to accommodate a view which does not include the idea of "real" parents or "real" children. IVF and surrogacy create possibilities well

beyond the average thoughts of would-be parents. Using IVF techniques, an embryo could be implanted in a surrogate mother, who could then turn over the resultant child to an adoptive couple. Without even considering the possiblity of divorce and remarriage on the part of the adoptive couple, the child could in effect have five different persons as "parents" (i.e., sperm donor, egg donor, surrogate mother, adoptive mother and father). **Who will be responsible for providing the social services and support needed by people left grappling with these issues?**

This kind of fragmentation of the processes of pregnancy and parenting will demand that our society clearly articulate and expand the meanings of concepts such as "mother," "father" and "family." To date, it is blatantly clear that our society is unable to do so. The predominant view of a "family" in our society is one of the traditional nuclear unit: one mother, one father and "their" child or children. Surrogate mothers are seen as "third parties" and are demeaned "by limiting them to a biological function." They are seen exclusively as "containers" or "maternal environments" -- as "nonpersons" *(McCormack, 1988, 369).*

Such fragmentation also puts in jeopardy our society's concept of "person." Just as we are beginning to embrace more holistic ways of viewing ourselves, our health and our well-being, the new reproductive technologies threaten to throw us back to a world view in which our value resides in not who we are, but what we have: bodily parts that represent valuable human resources. Women, in particular, will be extremely vulnerable to the risks of such fragmented thinking. Will our society eventually be in a position where certain women provide their eggs, others their uteruses and still others their guidance and care for children? **Most importantly, who will make these decisions and which criteria will be used?**

2. Procedures and Techniques which Focus on the Embryo or Fetus

A. General

Advances in medicine, particularly in the area of fetal surgery, have not only created treatments directed toward the improvement of the health of the embryo/fetus and mother but have also led to the further fragmentation of pregnancy. **An important aspect of this is the increasing tendency to view the fetus or embryo as another patient, or even person, separate and distinct from the mother. Once again, the potential exists for a mother and the**

embryo/fetus to be viewed as adversaries. Once again, the question of control becomes a central concern for women as decisions are being made which affect their bodies and their well-being.

This separation of mother and fetus or embryo has profound implications for women and their ability to make choices about treatment they will receive from professionals such as physicians and lawyers. In a wider sense, it affects the basic way women are viewed by society at large. Women are at risk of losing control over decisions regarding the birthing process, treatment they receive throughout a pregnancy, interventions aimed at terminating a pregnancy, and even procedures that take place before conception. Once the embryo/fetus is given legal or social status as a separate being, the possibility exists that someone other than the woman of whose body it is a part, will be granted the authority to make choices about the welfare of that embryo/fetus. Such a step removes responsibility from women and leaves them in an inferior position. Not only are women then seen as having no right to exercise choice, but they are also assumed to be incapable of assuming such responsibility.

In Canada and the United States, there have been alarming indications in recent court decisions and in legislation that women are being seen primarily as environments for the production and raising of children. In Ontario, a woman was committed under a mental health warrant in order to protect her fetus (Re Children's Aid Society of City of Belleville and T. (1987), 59 O.R. (2d) 204). In British Columbia, a woman who initially refused her consent for a cesarean section but eventually agreed to the procedure lost custody of her child (Re Baby R. (1987), 9 R.F.L. (3d) 415; reversed 15 R.F.L. (3d) 225). The British Columbia Supreme Court eventually reversed the lower court's decision, but it is clear that the question of autonomy for pregnant women remains unsettled. **Provinces and states continue to introduce legislation aimed at granting authority to the state or another third party to intervene and make decisions about pregnant women's conduct and behaviour, ostensibly to protect the interests of the fetus. This represents a failure to recognize women as autonomous individuals, with a right to exercise control over their own bodies. It is also a failure to recognize their claim to motherhood as a relationship between themselves and their embryos/fetuses.**

B. Pre-natal Diagnosis and Treatment

The ability to identify certain risks and abnormalities and, in some cases, to provide treatment aimed at reducing or correcting them, is a much valued part of the new technologies. Certainly, most women would not wish to relinquish the range of choices that are now available to them. For example, women may now be able to choose to terminate a pregnancy where it is discovered that the embryo/fetus is unhealthy; or alternatively, they may be able to choose to continue with the pregnancy while making necessary plans and adaptations in their lives in order to accommodate the needs of such a future child. Women may be able to choose where they wish to give birth to a child, taking into account information provided to them which may give some indication of the risks and benefits of a hospital birth versus a home birth. However, it is not possible for women to exercise this kind of choice without also having a substantial degree of control over all the factors that go into the making of such a choice. **Women need not only information, but also freedom to make a free and real choice. A woman who is not informed fully will be restricted by the range of choices open to her. A woman who is restricted from exercising choice will not be helped by the provision of information. These two elements cannot be separated.**

Equally inseparable are the embryo/fetus and mother. It is not possible to make any choice about one that will not affect the other. The designation of the embryo/fetus as a patient is an attempt to change what is not alterable: There is no realistic way to separate the embryo/fetus from the woman who carries it. Any perspective that logically follows from such a separation will lead to an untenable position. **Viewing both the embryo/fetus and the woman as patients moves them into potentially conflicting positions, for most of which we can provide no satisfactory resolution.**

While it is undeniable that there are benefits attached to most interventions directed toward the health of the embryo/fetus or mother, it is also true that there are always risks as well. Whenever someone other than the woman whose body contains the embryo/fetus intervenes and makes a decision which is contrary to the woman's own choice, **there is a societal presumption that such intervention is based upon the best interests of the embryo/fetus or of the woman herself. Furthermore, there is an additional societal presumption that the intervention is informed by scientific knowledge and that it therefore represents the "best" or "correct" decision. Both of these societal presumptions can and should be challenged.** Experience has shown that errors can be made by physicians and courts, and not only by women. For

example, physicians have asked courts to order cesarean sections in some cases where women have refused their consent for such procedures. In some of these cases, the women involved had healthy vaginal births before the surgeries could be performed. Unfortunately, such outcomes are often viewed as "lucky," rather than as evidence of a human or technological error *(Rothman, 1989, 166)*.

This does not mean that scientific knowledge is not valuable, but it does indicate that society cannot assume that medical knowledge is infallible. **It is necessary to consider that while women may make choices that are based on their own needs and values, so too do those people who intervene, ostensibly as objective and neutral parties.** It is important not to assume that when women make choices that stand in opposition to the prevailing medical authority, they are not acting in the "best interests" of the embryo/fetus. Nor can it be assumed that medical authority is always acting in the "best interests" of the embryo/fetus. As Rothman *(1989, p. 167)* says: "Just as women are not the natural enemy of the fetus, doctors are not their natural protectors."

There is an alarming trend toward a view that sees women's wombs as faulty or even dangerous environments for the "production" of fetuses. This perspective opens the way for "mother-blaming" whenever anything goes wrong, as well as for the creation of artificial wombs. To quote Joseph Fletcher: "Contrary to popular sentiment the womb is a very dangerous place -- a hazardous environment. The glass womb will offer a much safer and more easily monitored container for fetuses, a place where they can be more easily manipulated for treatment and salvation" (in Clement, 1985, 17). It would be well to ask what these fetuses would be saved from -- and for. Perhaps a "glass womb" could protect a developing fetus from some hazards, but once out of that artificial environment, the fetus will eventually be exposed to the same risks as are biological mothers -- and the rest of us. The reason that fetuses are exposed to dangers is because their mothers are also exposed.

Furthermore, it is only possible to speculate about some of the benefits offered by a mother's womb. There is very little information about what the effects of losing those benefits would be on a fetus, and currently, there does not seem to be a moral way in which to find out. It is necessary to exercise extreme caution in this area of research and **to resist the idea that women can be dispensed with in the processes of human reproduction. Again, there is a great**

deal that could be accomplished if more attention were paid to prevention.

C. Genetic Manipulation

The new reproductive technologies also hold the promise of ultimate human control over the reproductive process. The ability to detect and identify very specifically which genes contribute to which characteristics opens the way for manipulation of the complex patterns which form the foundation of human life. The ability to alter genetic material immediately raises question about who will decide which changes should be made and how.

There are again some underlying assumptions which must be examined. Some researchers are genuinely concerned to limit their explorations to finding ways of eliminating the causes of pain and suffering in people whose genes have destined them to lives of hardship or disability. Other researchers have shown less restraint in expressing their aspirations for genetic manipulation. They write about not only eliminating what many might agree are "flaws" but they also envision a future where a kind of genetic "streaming" would be used. Decisions could be made about the kinds and numbers of people which should be created in order to fulfill the requirements of society.

Most of these researchers suggest the creation of some sort of committee as a decision-making body, but who would be the committee members? Presumably, they would need to represent the "best" -- but of what? Would such a committee consist of intellectuals? scientists? the wealthy and powerful? the educated? men, women or both? **What role will women play on such a committee or even in such a society**

There is an equally pressing need for our society to evaluate and priorize goals and procedures from within a wider social context in which the values of the scientific community would form only one part of the general analysis and setting of policy. **In particular, the voices of women must be heard and heeded.**

D. Sex Pre-Selection

As one of the abilities already realized through the use of the new reproductive technologies, the issue of sex pre-selection has received considerable analysis. **Of special concern to many women is the well documented and pervasive preference of people all over the world to have male children, especially as first borns.** The consequences of a general preference for male children have already been seen in countries such as India, where in one study 7,997

of 8,000 aborted fetuses were female *(McCormack, 1988, 366)*. The long-term effects of a proliferation of males have also been the subject of speculation. The scarcity of females might mean that women would become highly valued; but it also seems likely that this value would be largely based on their ability to provide children for men.

Even where social and economic circumstances permit or encourage the creation of families with several children, there is good evidence of a preference for first born children to be male. In view of research which suggests that first born children tend to be high achievers in the professional world while second born children tend to be "socially adept and popular," deep concern has been expressed about the effects that a preference for male first borns would have on future generations of women *(Overall, 1987, 30)*. **The critical issue lies with the societies which encourage this preference, not with the technology per se.** Considering that women remain, in general, severely handicapped in their efforts to achieve equality with men, a socially sanctioned preference for male children or for male first borns can only be expected to add to the obstacles now facing women. Furthermore, it can be argued that society benefits from having women and men who have mixed places in birth order. **Our society needs both men and women who are "achievers" and "socially adept" because it**

seems likely that the two genders may use these abilities in different and important ways.

3. Use of Fetal Tissue and "Genetic Material" in Research on and Treatment of Disease, or for Other Purposes

The issues surrounding the use of fetal tissue and "genetic material" are connected to the issue of control. They are also predicated on socio-cultural ideas about the concept of ownership. As the new reproductive technologies help to strengthen the view that reproductive processes can be fragmented and broken down into discrete parts, it is inevitable that our society will be left to grapple with decisions about who owns those parts.

For the most part, when referring to the use of fetal tissue or "genetic material" there is an implied reference to techniques which involve the invasion of women's bodies. It is possible to make use of this tissue and material after it has been removed from women's bodies, but at some point it must nevertheless be removed. In fact, it is by no means clear that any real distinction has been made between that which is within a woman's body and that which has already been removed. For example, tissue obtained from aborted fetuses has been used in research and treatment *(Lafave, 1988, 29)*, and there is continuing debate as to

whether consent from the women involved is legally necessary or morally required. Women in IVF programs give up "extra" embryos but have no control over their use. Women who have undergone gynecological surgery have had eggs and ovarian tissue removed and "donated" to researchers *(Overall, 1987, 158)*. In some cases, women are aware that specific material is being removed from their bodies; in other cases, they do not know about the removal of the material. However, **whether or not they are aware that the material is being removed, women may have no knowledge of the uses to which it is eventually put.**

Strong arguments can be made in favour of granting ownership of fetal tissue or "genetic material" to the women from whose bodies it has come. There are persuasive precedents for this assertion because of the general presumption of the necessity for informed consent from the person who gives up any part of her or his own body. It is not justifiable that any person should take and use, for whatever purpose, part of another person without that person's informed consent. **The Council believes it is not morally right to take blood, skin or organs from a person without their informed consent, no matter how urgent the need.** This prohibition runs deep enough that body parts from a dead person are not taken without the informed consent of those viewed as closest in relation to her or him. Our society's moral reasoning is strongly influenced by its

belief that a person owns her or his body, with all its parts, and therefore must have the final say about what is done to those parts. In some cases, where the person in question is unable to give informed consent, this authority is extended to another person who has been chosen by the individual to fulfill this function.

There is no doubt that benefits are available from using fetal tissue or "genetic material." Distinctions need to be made among the possible kinds of use. Donations of organs are segregated between donations for the purposes of transplant and the purposes of research because of differences in individual thinking and sensibilities. Questions as to who benefits from donations of tissue or material must also be asked. **However, the central focus must be on the aspect of donation -- who has the right to give – and not on the question of who benefits, or who has the right to take. The Alberta Advisory Council on Women's Issues strongly believes that women must make these decisions for themselves.**

CONCLUSION

Women must be active participants in all the decision-making processes associated with the new reproductive technologies because of the intimate connection between these technologies and women's bodies.

Women must be viewed as whole persons, rather than as a collection of reproductive parts. Fragmentation of the process is a fragmentation of women.

There is an equally pressing need for our society to evaluate and priorize goals and procedures from within a wide social context in which the values of the scientific community would form only one part of the general analysis and policy setting. **In particular, the voices of women must be heard and heeded.**

This does not mean that scientific knowledge is not valuable, but it does indicate that society cannot assume that this knowledge is infallible. It is necessary to consider that while women may make choices that are based on their own needs and values, so too do those people who intervene, ostensibly as objective and neutral parties.

A woman who is not informed fully will be restricted by the range of choices open to her and a woman who is restricted from exercising choice will not be helped by the provision of information. These two elements cannot be separated.

The Alberta Advisory Council on Women's Issues is aware that new reproductive technologies can benefit women and our society as a whole. We do not disagree with the development of these technologies, our concerns lie in their application. The Council supports the need for continued research and urges the Royal Commission to make recommendations which give women absolute and final choice and control over their own reproductive destinies.

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